

ATTACHMENT 5: COMPANION GUIDE



Department of Human Services

DH94STARS

Division of Alcohol & Drug Abuse (DADA)

Division of Mental Health (DMH)

HIPAA Transaction Standard Companion Guide

Section 1

Refers to the ASC X12N Insurance Implementation Guides - Version 004010A

Companion Guide Version 1.0

April 2007

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Disclosure Statement:

The South Dakota Department of Human Services-DADA and DMH has developed this Companion Guide to help its Trading Partners exchange electronic claim and remittance information with the South Dakota DH94STARS Application. Conforming to the information in this guide is not a guarantee of transaction acceptance or of subsequent payment.

This Companion Guide is a work in progress. The DADA and DMH reserve the right to change this Companion Guide at any time without notice.

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Preface:

This Companion Guide to the ASCX12N Implementation Guides adopted under HIPAA clarifies and specifies situational data elements and plan-specific values that must be included in transactions that are transmitted electronically to the South Dakota Department of Human Services-DADA & DMH DH94STARS system. Transactions based on the information contained in this companion document, used in tandem with the X12N Implementation Guides, should ensure compliance with both X12 syntax and usage.

This Companion Guide is not intended to convey information that in any way modifies or exceeds the data requirements and usage as expressed in the Implementation Guides adopted under HIPAA.

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1. Introduction:

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 include provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1 Purpose of the Companion Guide

The HIPAA EDI Transaction Standard Companion Guide explains the procedures necessary for Trading Partners of the South Dakota Department of Human Service-DADA & DMH to transmit Electronic Data Interchange (EDI) transactions.

These transactions could include:

835 - Health Care Claim Payment/Advice

837 - Health Care Claim: Professional

This Companion Guide is not intended to replace the X12N Implementation Guides; rather it is to be used in conjunction with them. In addition, the Companion Guide conveys information that is within the framework and structure of the X12N Implementation Guides but does not contradict or exceed them. For a copy of the X12N 837P Implementation Guides go to www.wpc-edi.com/content/view/400/160/.

1.2 Overview

This Companion Guide includes sections that describe the methods of electronic exchange that are supported by the department, department specific transaction usage rules and limitations, transaction acknowledgment, and finally a sample trading partner agreement.

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1.3 Transaction Support

The South Dakota Department of Human Services–DADA & DMH supports the receipt of the following inbound transactions:

- 837 - Health Care Claim: Professional
- 997 – Functional Acknowledgement

In addition to the inbound transactions, the department will also generate the following transactions:

- 835 - Health Care Claim Payment/Advice
- 997 – Functional Acknowledgement

1.4 References

The following Implementation Guides were utilized in the development of this companion guide:

Health Care Claim Payment/Advice	ASC X12N 835 (004010X091A1)
Health Care Claim: Professional	ASC X12N 837 (004010X098A1)

2. Connectivity with the Department / Communications:**2.1 Methods of Electronic Exchange**

South Dakota State Portal named Launchpad (DP96X12) is used for electronic transmission of X12 837,835 Files.

- Providers need to login to Launchpad system by using login name & password provided by the Agency.
- Providers can upload X12 837P files to the Agency.
- Providers can download X12 997, 835 files through Launchpad itself.

Notes: Provider need to become a trading partner of the Dept. of Human Services to use this portal. See contact information section for details. DHS will not allow any other methods to transfer X12 files.

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3. Payer Specific Rules and Limitations:

This section describes specific data element values and situational segments, required by the department to properly process each inbound transaction. This information is within the framework of the *ASC X12N Implementation Guides*, adopted for use under HIPAA. The Companion Guide does not in any way exceed the requirements or usage of data expressed in the Implementation Guides. The information might for example:

- Indicate a desired number of repeats of an identified loop, or segment
- Specify a sub-set of Implementation Guide internal code listings needed by the department
- Limit the size of a particular element
- Clarify the use of loops, segments, composite and simple data elements
- Explain other information tied directly to a loop, segment, or composite or simple data element pertinent to electronic transactions with the department.

Provider Billing Requirements:

The following items are very important for processing 837 Health Care Claim transactions by DHS adjudication system.

- DHS will validate and accept or reject the entire Interchange control structure (ISA/IEA envelope)
- Subscriber must be same as Patient. (2000B loop SBR02 = 18)
- Procedures calculated with minutes must be converted into units of payment. (2400 Loop SV103 below for more details.)
- Replacement and void transactions require the DHS reference number obtained from 835 remittance advice transaction (2100 loop CLP07 field) or the online Claims Remittance Report be submitted as the original reference number (837 P 2300 Loop, REF01=F8, REF02=Original Reference Number).

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LEGEND:

SHADED rows represent “segments” in the X12N implementation guide

NON-SHADED rows represent “data elements” in the X12N implementation guide.

“Loop – specific” comments should be indicated in the first segment of the loop.

3.1 837 Health Care Claim: Professional (004010X098A1)

The Department supports the 837 Health Care Claim: Professional transaction in a batch mode.

Page	Loop ID	Reference	Name	Codes	Length	Notes/Comments
645	Outer	GS08	Version / Release	004010X098A1		The DHS will only support Health Care Claim Professional transactions that incorporate the changes identified in the addenda published October 2002.
64	Header	BHT02	Transaction Set Purpose Code	00		Use '00' Original
64	Header	BHT04	Transaction Set Creation Date			Submission Date is gathered by DHS from this date field.
65	Header	BHT06	Transaction Type Code	CH		DHS accepts only Chargeable Claims (CH) and data reporting (RP) codes will be rejected.
75	1000B	NM109	Receiver Primary Identifier	SDDHSSTARS	10	All transactions should contain the ID “SDDHSSTARS” to identify the DHS as the claim receiver. Any transaction received without this ID will be rejected.
2010AA Loop - Professional Billing/Pay-to-Provider Hierarchical Level						
86	2010AA	NM108	Identification Code Qualifier	24		Code 24 = Employer’s Identification Number (FIN) The claim will be rejected if it is different. This will change when NPI becomes mandated for use. At that time this will be XX.
86	2010AA	NM109	Identification Code		9	Employers Identification Number, FIN. NO DASHES should be entered. It is a required to process the claim. This will be the NPI when it’s mandated for use.
92	2010AA	REF01	Reference Identification Qualifier	EI		REF01 & REF02 is mapped for future use when NPI is mandated. This will be required to EI = Employer’s Identification Number (FIN) when NPI becomes mandatory.
92	2010AA	REF02	Billing Provider Secondary Identification Number		9	This will be required to be Employers Identification Number FIN when NPI becomes mandatory.

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Page	Loop ID	Reference	Name	Codes	Length	Notes/Comments
2010AB Loop - Professional Pay To Provider Information						
101	2010AB	NM108	Identification Code Qualifier	24		Code 24 = Employer's Identification Number (FIN). The claim will be rejected if it is different. This will change when NPI becomes mandated for use. At that time this will be XX. Payments will be sent to the Pay To Provider identified in this loop. Remittance information will be sent to the Billing Provider identified in loop 2010AA.
101	2010AB	NM109	Identification Code		9	Employers Identification Number, FIN. It is a required to process the claim. This will be the NPI when it's mandated for use.
106	2010AB	REF01	Reference Identification Qualifier	EI		REF01 & REF02 is mapped for future use when NPI is mandated. This will be required to EI = Employer's Identification Number (FIN) when NPI becomes mandatory.
107	2010AB	REF02	Pay-to Provider Secondary Identification Number		9	This will be required to be Employers Identification Number, TIN when NPI becomes mandatory.
2000B Loop - Professional Subscriber/Patient Information						
109	2000B	HL04	Hierarchical Child Code	0		To process a claim, subscriber must be the patient. Any claim which contains dependent level information will be denied.
111	2000B	SBR02	Individual Relationship Code	18		Subscriber is same as patient indicator. If this code is not 18, then the claim will be rejected by DHS
2010BA Loop – Subscriber Name						
119	2010BA	NM108	Identification Code Qualifier	MI		Member Identification Number
119	2010BA	NM109	Subscriber Primary Identifier		15	The unique client ID established in STARS. The claim will be rejected by DHS if this does not match the unique client ID in STARS.
2010BB Loop – Payer Name						
131	2010BB	NM108	Identification Code Qualifier	PI		Payer Identifier
131	2010BB	NM109	Payer Identifier	SDDHSSTARS	10	All transactions should contain the ID “SDDHSSTARS” to identify the payer. Any transaction received without this ID will be denied.

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Page	Loop ID	Reference	Name	Codes	Length	Notes/Comments
2300 Loop - Professional Claim Information						
171	2300	CLM01	Claim Submitter's Identifier			Patient Claim/Invoice Number in Provider's accounting system.
172	2300	CLM02	Total Claim Charge Amount			Total Claim Charge Amount. Total amount for all lines submitted on this claim.
174	2300	CLM05-3	Claim Frequency Type Code	1 or 7 or 8		Permissible code values: 1-Original, 7-Replacement & 8-Void. If code is 6-Corrected, then the claim will be rejected. 7 & 8 only apply to claims previously submitted and finalized.
179	2300	CLM20	Delay Reason Code			This is required if any claim lines being submitted are past 90 days. Required if Date DHS Process Claims is >= Service End Date + 90 days.
217	2300	CN101	Contract Type Code	09		09 is the suggested code for this element.
218	2300	CN104	Contract Code		16	This is the contract number assigned by DHS to each service contract. If the contract number is not submitted at the service line loop (2400 CN104) it must be submitted here. The service dates must fall in line with the contract period. Include all 12 digits of the contract number. Do not include – or spaces.
220	2300	AMT02	Patient Amount Paid			Any amount paid by the client towards and service on this claim must be entered here. This amount is for the entire claim not a single service line.
230	2300	REF01	Reference Identification Qualifier (Original reference number qualifier)	F8		Required if the claim is resubmitted and frequency type code is 7 or 8. F8=Original reference number qualifier. If this field is missing, the claim will be rejected.
230	2300	REF02	Claim Original reference number		16	Original reference number is required if the claim is replacement or void. If it is missing for replacement or void transactions, then the claim will be rejected.
332	2320	AMT01	Amount Qualifier Code	D		D is the Prior Paid Amount Qualifier code. This code is a required field.
332	2320	AMT02	COB Payer Paid Amount			Total COB paid by other payers is calculated by DHS from this loop. It is required to provide all prior payment amounts by other payers in this loop.
2400 Loop – Professional Service Line Information						
401	2400	SV101-1	Product or Service ID Qualifier	HC		Service ID Qualifier code 'HC' is only supported at this time.
401	2400	SV101-2	Procedure Code			Ref code for the service.

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Page	Loop ID	Reference	Name	Codes	Length	Notes/Comments
401	2400	SV101-3	Procedure Modifier 1			Modifiers identify special circumstances related to the performance of the services. It is required to fill in the modifiers if it exists to calculate the correct payment.
402	2400	SV101-4	Procedure Modifier 2			Modifiers identify special circumstances related to the performance of the services. It is required to fill in the modifiers if it exists to calculate the correct payment.
402	2400	SV101-5	Procedure Modifier 3			Modifiers identify special circumstances related to the performance of the services. It is required to fill in the modifiers if it exists to calculate the correct payment.
402	2400	SV101-6	Procedure Modifier 4			Modifiers identify special circumstances related to the performance of the services. It is required to fill in the modifiers if it exists to calculate the correct payment.
402	2400	SV102	Charged Amount			Service Line level charged amount.
403	2400	SV103	Measurement Code	UN		DHS does not support F2 (International Units) & MJ (Minutes).
403	2400	SV104	Units/Quantity			All units should be whole units.
436	2400	DTP02	Date Time Period Format Qualifier	D8 or RD8 for the date ranges		D8 format = CCYYMMDD RD8 format = CCYYMMDD- CCYYMMDD
436	2400	DTP03	Service Date			Service Start Date and Service End Date are gathered by DHS system from this field. If D8 is used then Start Date and Service End Date will be the same date for processing.
466	2400	CN101	Contract Type Code	09		09 is the suggested code for this element.
467	2400	CN104	Contract Code		16	This is the contract number assigned by DHS to each service contract. If the contract code is entered here it will over ride the contract code at the claim level (2300 CN104) for this individual line. The service dates for this service line must fall in line with the contract period. Include all 12 digits of the contract number. For DHS purposes, all CN104 should have the same contract number on claim. Do not include – or spaces.
554	2430	SVD02	Service Line Paid Amount			Total COB paid by other payers is calculated by DHS from this loop. It is required to provide all prior payment amounts by other payers in this loop.

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4. Control Segments / Envelopes

This section describes South Dakota Department of Human Services–DADA & DMH use of the interchange control and functional group control segments. It includes a description of expected sender and receiver codes, authorization information, and anticipated data values.

4.1 Interchange Control Header:

The following table lists each of the elements and sample values of the Interchange Control Header (ISA) segment. The ISA should accompany every transaction and should not vary from transaction to transaction.

Reference	Name	Codes	Notes/Comments
ISA01	Author Information Qualifier	00	No Authorization Information Present
ISA02	Author Information		Blank
ISA03	Security Information Qualifier	00	No Security Information Present
ISA04	Security Information		Blank
ISA05	Interchange Sender ID Qualifier	ZZ	Mutually Defined Sender ID Qualifier
ISA06	Interchange Sender ID	xxxxxxx	The Sender ID will be established during Trading Partner Registration.
ISA07	Interchange Receiver ID Qualifier	ZZ	Mutually Defined Receiver ID Qualifier
ISA08	Interchange Receiver ID	SDDHSSTARS	All Transactions destined for the department must contain this ID.
ISA09	Interchange Date	YYMMDD	The date the transaction was generated
ISA10	Interchange Time	HHMM	The time the transaction was generated
ISA11	Standards Identifier	U	
ISA12	Interchange Version Number	00401	
ISA13	IC Control Number	nn	Must be unique by Trading Partner. *
ISA14	Acknowledgment Requested	1	997s will be generated for all batch transactions received by the Department of Human Services – DRS & SBVI

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Reference	Name	Codes	Notes/Comments
ISA15	Usage Indicator		Used as appropriate
ISA16	Composite Element Separator		Determined by the sender

- Re-transmitted transactions are identified by the Interchange Control Number is ISA14. If a transaction has previously been received and processed by the department, an error will be generated when the re-transmission is received.

4.2 Functional Group Header:

The following table lists each of the elements and sample values of the Functional Group Header (GS) segment. The ISA should accompany every transaction and should not vary from transaction to transaction.

Reference	Name	Codes	Notes/Comments
GS01	Functional Identifier Code	HC	Health Care Claim
GS02	Application Sender's Code	xxxxxxx	The Sender ID will be established during Trading Partner Registration and will be the same as ISA06.
GS03	Application Receiver's Code	SDDHSSTARS	All Transactions destined for the department must contain this ID.
GS04	Date	CCYYMMDD	The date the transaction was generated
GS05	Time	HHMM	The time the transaction was generated
GS06	Group Control Number	xxxxxxx	The Sender ID will be established during Trading Partner Registration.
GS07	Responsible Agency Code	X	
GS08	Version / Release / Industry Identifier Code	004010X098A1	Varies by Transaction Type The DHS will only support transactions that incorporate the changes identified in the addenda published October 2002, modifying the transactions that were originally published May 2000.

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5. Acknowledgments

5.1 997 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a functional group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. The benefit to this process is that the sending trading partner can determine if the receiving trading partner has successfully received the X12 transaction set.

The South Dakota Department of Human Services–DRS & SBVI will generate a 997 Functional Acknowledgment for every functional group within a “batch” transaction received by the department. This includes the receipt of the following transaction types:

- 837 - Health Care Claim: Professional

The Department of Human Services–DRS & SBVI expects to receive a 997 Functional Acknowledgement from a trading partner every time the partner receives a transaction from the Department.

6. Contact Information

If you have technical questions regarding the 837P or testing a transaction with DHS, contact Kurt Nussbaum at Kurt.Nussbaum@state.sd.us or (605) 773-2748.

To establish a Trading Partner Agreement with the South Dakota Department of Human Services–DADA and DMH (South Dakota DH94STARS system), contact Sacha Wise at Sacha.Wise@state.sd.us or (605) 773-5990.

7. Sample Trading Partner Agreement

Trading partner agreement means an agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction. [Part§ 160.103 Definitions.] This section is designed for those who intend to send and receive electronic transactions in HIPAA-specified ANSI-x12N standards. [Click here to view the Trading Partner Agreement.](#)